

*A product of  
"Assessing the  
New Federalism,"  
an Urban Institute  
Program to Assess  
Changing Social  
Policies*

# Health Policy for Low-Income People in Mississippi

*Leighton Ku, Alicia Berkowitz,  
Frank Ullman, and Marsha Regenstein*

**W**hile many states are undergoing rapid health policy changes and upheavals, Mississippi has followed a different course. One reason is that the state faces economic and health disadvantages, such as poverty and poor health status, at a level not found in most other states. Another factor is that public and private payers in Mississippi have been less insistent about reducing health care spending than in other states. Thus, for example, capitated managed care has grown rapidly elsewhere but comprises only a small share of the market in Mississippi.

Mississippi's long-standing socioeconomic problems create serious challenges in the state's efforts to aid low-income families. Despite these underlying difficulties, Mississippi has many reasons for optimism. The state economy has grown rapidly in recent years, and the state government is fiscally strong, partly because of a boost in revenues from legalized gambling. New developments, including the state's settlement of the lawsuit over Medicaid spending on tobacco-related illnesses and the new State Children's Health Insurance Program, suggest that the state should have resources for additional health expenditures in the future.

## State Characteristics

Mississippi is primarily a rural state: Two-thirds of its 2.6 million residents live in nonmetropolitan areas. Three-fifths of residents are white, and about two-fifths are African-American (table 1). Mississippi is, and has been for many years, one of the poorest states in the nation. About 23 percent of its total population, and 34 percent of children, had income below the federal poverty level in 1994. These rates were about 60 percent higher than the national averages. The unemployment rate is relatively high, and wages tend to be low. Mississippi's per capita income in 1995 was 28 percent below the national average. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state. Even so, by most accounts, Mississippi is a very poor state.

On the positive side, Mississippi has had a vigorous economic boom for several years. The state's per capita income grew 31 percent between 1990 and 1995, well above the national growth rate of 21 percent. One factor in the economic development has been the construction of casinos, which have helped revitalize some areas of the state. The state has

**The state faces economic and health disadvantages, such as poverty and poor health status, at a level not found in most other states. . . . Despite these underlying difficulties, Mississippi has many reasons for optimism.**

**Table 1**  
**State Characteristics**

	<u>Mississippi</u>	<u>U. S.</u>
<b>Sociodemographic</b>		
Population (1994–95) (in thousands)	2,600	260,202
Percent under 18 (1994–95)	27.4%	26.8%
Percent 65+ (1994–95)	12.3%	12.1%
Percent Hispanic (1994–95)	0.7%	10.7%
Percent Non-Hispanic Black (1994–95)	38.7%	12.5%
Percent Non-Hispanic White (1994–95)	60.0%	72.6%
Percent Non-Hispanic Other (1994–95)	0.6%	4.2%
Percent Noncitizen Immigrant (1996)*	0.9%	6.4%
Percent Nonmetropolitan (1994–95)	66.3%	21.8%
Population Growth (1990–95)	4.7%	5.6%
<b>Economic</b>		
Per Capita Income (1995)	\$ 16,683	\$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	31.3%	21.2%
Unemployment Rate (1996)	6.1%	5.4%
Percent below Poverty (1994)	22.8%	14.3%
Percent Children below Poverty (1994)	34.4%	21.7%
<b>Health</b>		
Percent Uninsured—Nonelderly (1994–95)	20.1%	15.5%
Percent Medicaid—Nonelderly (1994–95)	15.9%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	56.9%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	7.1%	6.2%
Smokers among Adult Population (1993)	24.1%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	9.9%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	10.6	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	74.3	54.4
Violent Crimes per 100,000 (1995)	502.8	684.6
AIDS Cases Reported per 100,000 (1995)	16.4	27.8
<p><i>Source:</i> Complete list of sources is available in <i>Health Policy for Low-Income People in Mississippi</i> (The Urban Institute, 1997).</p> <p>* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.</p>		

also been able to attract other businesses, because of the low cost of living and other favorable business conditions.

About 20 percent of nonelderly Mississippians were uninsured in 1994–95, compared with 16 percent nationwide. This is a high rate of uninsurance, although there are more prosperous states, such as Texas, with higher uninsurance levels. The main factor that explains Mississippi's rate of uninsurance is that its level of employer-sponsored insurance (57 percent) is low compared to other states. Although Mississippi's Medicaid program has stringent eligibility standards relative to other states' programs, because of Mississippi's high

poverty rate, a large fraction (16 percent) of the state population participates in Medicaid.

By a number of public health measures, Mississippians have relatively poor health status compared to residents of other states. When measured by premature mortality (years of life lost before age 65, race-adjusted), Mississippi ranks as the 50th state. Key factors that contribute to the state's health burdens include high levels of heart disease and motor vehicle deaths and relatively high rates of smoking, cancer, and infant mortality. On the other hand, Mississippi has among the highest child immunization rates in the nation.

## Political and Fiscal Environment

Mississippi has a long tradition of conservative politics. Currently, political power is shared by Republicans and Democrats. Governor Kirk Fordice, in his second term of office, is a Republican, as are the state's two United States senators and three of its five congressmen. The lieutenant governor and a majority of both legislative chambers are Democrats.

Like many other southern states, Mississippi limits the powers of the governor and vests relatively more power in the legislature and independent agencies. The governor appoints some agency heads, including the directors of the Division of Medicaid and the Department of Human Services; however, other agencies, such as the public health and mental health departments, have directors selected by independent boards. The state legislature controls many of the state policies and the purse strings, but there is a relatively brief legislative session and there are few legislative staff. Thus, the executive agencies shape much of the agenda for the legislature.

The state treasury has fared very well in recent years as a result of general economic development and legalized gambling. Reflecting its strong fiscal position, the state had a rainy day fund of about \$400 million as of early 1997. State revenues are projected to grow more slowly in the future, in part because gambling revenue is leveling off.

## Medicaid Expenditure Trends

Medicaid is the second largest program in the Mississippi state budget, comprising 22 percent of total (federal and state) expenditures in 1995. However, Medicaid accounted for only 5 percent of state general fund spending in 1995. The rest of the Medicaid funding came from federal matching dollars and revenue contributed by health care providers, which may be counted as state matching funds. Mississippi has the highest federal Medicaid matching rate in the country—77.2 percent in 1997. The state has expanded the use of inter-

**Table 2**  
**Medicaid Expenditures**  
**by Eligibility Group and Type of Service,**  
**Mississippi and United States**  
 (Expenditures in Millions)

	Mississippi			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990-92	1992-95	1995	1990-92	1992-95
<b>Total</b>	<b>\$1,558.3</b>	<b>31.3%</b>	<b>11.8%</b>	<b>\$157,872.5</b>	<b>27.1%</b>	<b>9.9%</b>
<b>Benefits</b>						
Benefits by Service	\$1,341.4	22.4%	13.0%	\$133,434.6	18.8%	11.0%
Acute Care	938.1	20.2%	15.4%	79,438.5	22.1%	13.0%
Long-Term Care	403.3	27.0%	8.0%	53,996.1	14.8%	8.3%
Benefits by Group	\$1,341.4	22.4%	13.0%	\$133,434.6	18.8%	11.0%
Elderly	\$400.1	24.9%	8.8%	\$40,087.4	16.7%	8.1%
Acute Care	160.7	14.4%	16.3%	9,673.7	18.5%	11.9%
Long-Term Care	239.4	31.2%	4.6%	30,413.7	16.2%	7.0%
Blind and Disabled	\$556.4	21.7%	19.9%	\$51,379.4	17.7%	12.9%
Acute Care	406.5	23.7%	23.3%	29,760.7	22.8%	15.2%
Long-Term Care	149.9	17.8%	12.3%	21,618.7	12.3%	10.1%
Adults	\$138.8	10.0%	5.4%	\$16,556.9	20.4%	9.2%
Children	\$246.1	29.7%	11.3%	\$25,410.9	24.3%	13.3%
<b>Disproportionate Share</b>	<b>\$182.6</b>	<b>683.2%</b>	<b>6.0%</b>	<b>\$18,988.4</b>	<b>261.5%</b>	<b>2.7%</b>
<b>Hospital Administration</b>	<b>\$34.3</b>	<b>16.5%</b>	<b>4.4%</b>	<b>\$5,449.4</b>	<b>9.8%</b>	<b>12.8%</b>

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

governmental transfers by public hospitals, used in tandem with disproportionate share hospital (DSH) payments, to draw down additional federal dollars with minimal use of state general funds.

Because of Mississippi's extensive reliance on federal matching funds and provider-related revenues and also given the state's robust economic condition, cutting Medicaid has not been a serious policy option in the past few years. Medicaid has been considered a "built-in" item in the budget. However, a projected deceleration in state revenue growth and a reduction in federal funding for DSH payments under the Balanced Budget Act of 1997 suggest that Mississippi could face increasing fiscal pressure to contain Medicaid spending. Nonetheless, additional federal funds available under the State Children's Health Insurance Program (\$56 million in 1998) and the windfall from the tobacco lawsuit settlement (about \$170 million for Mississippi in the first year, eventually totaling about \$3.6 billion) should more than compensate for DSH and state revenue cuts. Use of the State Children's Health Insurance Program funds

would require that the state contribute about \$10.7 million in matching funds. Although the tobacco settlement funds are a plausible source, there are still a number of unresolved issues about the use of these funds.

Mississippi's rate of Medicaid expenditure growth has been higher than the national average since at least 1990. The average annual growth rate in Mississippi was 31.3 percent from 1990 to 1992 and 11.8 percent from 1992 to 1995, compared with national averages of 27.1 percent and 9.9 percent, respectively (table 2). The two factors that particularly shaped the state's high growth rate from 1990 to 1992 were the large increase for DSH spending and substantial increases in spending per enrollee, especially among the elderly and children (table 3). From 1992 to 1995, growth in expenditures per enrollee moderated for all groups, although the growth rates remained higher than the national averages. Enrollment levels have held fairly steady since 1990; the largest increases have occurred within the blind and disabled category.

Although Mississippi's Medicaid expenditures grew quickly in the first

half of the 1990s, the level of spending per enrollee was generally lower than the national average. Spending per blind or disabled enrollee (\$4,150) was only about half the national average (\$8,022) in 1995. The average amount spent per child enrollee was \$869 versus \$1,178 nationally. One reason for the low per capita expenditures is that the state Medicaid program has tight limits on the number of hospital days, physician visits, and prescription drugs that may be used by beneficiaries. In addition, Mississippi has relatively low spending for long-term care services, largely because of restrictions on nursing home and home health care capacity. Thirty percent of its Medicaid expenditures on benefits are for long-term care compared with 40 percent nationwide.

### Medicaid Managed Care

In its 1997 session, the state legislature authorized statewide expansion of a primary care case management system for nondisabled, nonelderly Medicaid beneficiaries, called HealthMACS. HealthMACS requires that

**Table 3**  
**Medicaid Enrollment and Expenditures**  
**per Enrollee: Contributions to Total Expenditure Growth**

	Mississippi			United States		
	1995	Average Annual Growth		1995	Average Annual Growth	
		1990-92	1992-95		1990-92	1992-95
<b>Elderly</b>						
Total expenditures on benefits (millions)	\$400.1	24.9%	8.8%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	68.1	1.1%	0.5%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$5,872	23.6%	8.2%	\$9,738	11.0%	5.0%
<b>Blind and Disabled</b>						
Total expenditures on benefits (millions)	\$556.4	21.7%	19.9%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	134.1	8.7%	9.6%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$4,150	12.0%	9.5%	\$8,022	7.1%	3.1%
<b>Adults</b>						
Total expenditures on benefits (millions)	\$138.8	10.0%	5.4%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	78.9	-1.5%	-2.7%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$1,758	11.8%	8.3%	\$1,728	8.0%	4.4%
<b>Children</b>						
Total expenditures on benefits (millions)	\$246.1	29.7%	11.3%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	283.2	5.2%	0.1%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$869	23.3%	11.3%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

beneficiaries select (or be assigned) a primary care provider who serves as a gatekeeper to most medical services. After much debate regarding Medicaid managed care, the legislature rejected extending a Medicaid pilot project in which beneficiaries could voluntarily enroll in capitated health maintenance organizations (HMOs). A major stumbling block for the HMO pilot project was the difficulty in compelling health care providers to join the networks of the HMOs. Despite the setbacks, the state Medicaid agency is continuing its expansion of the capitated HMO projects, using other legislative authority. The planned expansion is modest (eight counties) in order to avoid confrontation with the legislature.

## Health Care Market and Insurance Activity

The obstacles facing the Medicaid HMO pilot project are not surprising, given the low level of commercial HMO activity in the state. As of the end of 1995, about 1 percent of the population was served by an

HMO, compared with 23 percent nationally. Industry data suggest that HMO penetration has since grown to perhaps 2 percent. The proportion of state residents using preferred provider organizations was unknown but was believed to be much larger than the proportion in HMOs. The relative shortage of physicians and other health care providers has made it difficult for HMOs to assemble provider networks. Further, there has been little demand from employers to create managed care plans. While state government officials and health care association representatives typically believe that the state will eventually see a more pronounced presence of managed care, change has been slow.

Mississippi has made a number of changes in insurance regulations in recent years, particularly in the area of small-group insurance. For example, it has placed limits on preexisting condition exclusions and established provisions for portability of insurance. As a result, few changes were needed to comply with the Health Insurance Portability and Accountability Act of

1996. The state has formed a high-risk insurance pool, which insures 1,500 people with serious health problems who would otherwise be uninsurable. The risk pool is funded by assessments on insurance companies, as well as member premiums.

## Long-Term Care

Mississippi has relatively unusual long-term care policies. A strict certificate-of-need system has prevented the opening of new nursing home beds and creation of new home health agencies. Given the restrictions on nursing home expansion as well as the higher-than-average length of stay in Mississippi facilities, it is not surprising that nursing homes in the state have a 99 percent occupancy rate on average. Mississippi's Medicaid program is disproportionately reliant on institutional care and uses very little home and community-based care. While home and community-based care services have grown rapidly in the state, they are dominated by Medicare and are still small in scope

compared to institutional services. Combining access to nursing homes and home health services, elderly and disabled Medicaid enrollees in Mississippi are about half as likely to obtain long-term care as beneficiaries in other states; this indicates a possible access problem. In the 1997 session, the state legislature considered changing the certificate-of-need system but elected to wait until the next session to address the issue.

## Welfare Reform

In 1997, the Mississippi legislature enacted a welfare reform bill, paralleling the 1996 federal welfare reform law. Although a number of changes were made in the cash welfare system, the bill had almost no explicit changes for Medicaid. Advocates in the state worried that welfare recipients who lose cash assistance may also lose Medicaid benefits, but it was too early to determine the effects of the new rules. As in other states, Mississippi's Aid to Families with Dependent Children caseloads were already declining prior to federal reforms, partly because of economic improvements and partly because of earlier state welfare reform efforts.

## Safety Net Providers

Associated with its high poverty rate and largely rural population, Mississippi has a low supply of health care providers compared with other states. In 1995, the state had the highest proportion of residents in the nation living in areas with health professional shortages. To address the shortages, the state has a relatively extensive network of publicly funded safety net providers—such as public hospitals, public health departments, and community health centers—that provide free or reduced-price health services. These safety net providers are far more important in Mississippi than in most of the nation. Examples of their importance are numerous: About half the pregnant women in Mississippi receive at least some of their prenatal care through public health departments. The proportion of Mississippians seen at community health centers (8.6 percent)

is about three times higher than the national average (2.7 percent). Finally, about half the hospitals in the state are state- or county-controlled (mostly county), an unusually high level among states. Although many of the county hospitals receive little subsidy from the counties, they nonetheless typically provide substantial charity care funded by DSH and cost-shifting from third-party payers.

The growth of Medicaid managed care in Mississippi may have repercussions for safety net providers. For example, health department officials were concerned that Medicaid managed care may decrease health departments' Medicaid revenues as patients shift to private physicians. Although this has already begun to occur, it has had only a modest effect on overall health department revenues so far. Community health centers have similar concerns, but the potential effects are greater since Medicaid makes up more of their total revenue. Public health officials also worry that emphasis on preventive health measures, such as immunizations, may deteriorate if private physicians are less aggressive in promoting preventive care among Medicaid recipients.

## Challenges for the Future

Mississippi faces a number of interesting and important choices in the near future. Among the most immediate issues are how it will respond to the new funds available through the State Children's Health Insurance Program and the tobacco lawsuit settlement. Other health policy issues include the future of long-term care services and of Medicaid managed care. For the long term, the state must decide whether it will embrace managed care on a broader basis, as has occurred elsewhere in the country. Lastly, Mississippi must also continue to address long-standing health care problems, including high rates of premature mortality and the shortage of health care providers.

## About the Authors

*Leighton Ku* is a senior research associate in the Urban Institute's Health Policy Center. His principal research interests include state health reform efforts and the financing of health care for low-income families. He teaches in the public policy program at George Washington University.

*Alicia Berkowitz* was a research associate with the Health Policy Center, where she studied Medicaid reform and managed care efforts in various states, including California. She also studied issues relating to long-term care, health care markets, and people dually enrolled in Medicare and Medicaid.

*Frank Ullman* is a research associate with the Health Policy Center, where he currently focuses on issues related to children's health insurance. He has conducted case studies on health care developments in Mississippi and New Jersey. His recent research examines the impact of managed health care on infant health.

*Marsha Regenstein* is vice president of the Economic and Social Research Institute, a nonprofit organization in Washington, D.C., that conducts research and policy analysis on health care and social services. She has written about children's health and early education, Medicare managed care, and persons with disabilities.

## Funders

*Assessing the New Federalism* is funded by the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W.K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the Commonwealth Fund, the Robert Wood Johnson Foundation, the Weingart Foundation, the McKnight Foundation, and the Fund for New Jersey. Additional support is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through grants to the University of Wisconsin at Madison.

This series is a product of *Assessing the New Federalism*, a multi-year project to monitor and assess the devolution of social programs from the federal to the state and local levels. Project co-directors are Anna Kondratas and Alan Weil. The project analyzes changes in income support, social services, and health programs and their effects. In collaboration with Child Trends, Inc., the project studies child and family well-being.

There are two *Highlights* for each state. The *Highlights* that focus on health cover Medicaid, other public insurance programs, the health care marketplace, and the role of public providers. The income support and social services *Highlights* look at basic income support programs, employment and training programs, child care, child support enforcement, and the last-resort safety net. The *Highlights* capture policies in place and planned in 1996 and early 1997. To receive the full-length reports on which the *Highlights* are based, contact the Urban Institute.

**Publisher:** The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

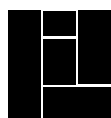
Copyright © 1998

Permission is granted for reproduction of this document, with attribution to the Urban Institute.

For extra copies call 202-857-8687, or visit the Urban Institute's web site (<http://www.urban.org>) and click on "Assessing the New Federalism."

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

Telephone: (202) 833-7200 ■ Fax: (202) 429-0687 ■ E-Mail: [paffairs@ui.urban.org](mailto:paffairs@ui.urban.org) ■ Web Site: <http://www.urban.org>



**THE URBAN INSTITUTE**

2100 M Street, N.W.  
Washington, D.C. 20037

Nonprofit Org.  
U.S. Postage  
**PAID**  
Permit No. 8098  
Washington, D.C.

*Address Correction Requested*